

5190

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark (rural)</b>				c. LENGTH OF STAY IN 1b <b>29 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route #1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>E.</b> Last <b>Adkins</b>				4. DATE OF DEATH Month <b>4</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/1889</b>		9. AGE (In years last birthday) yrs. <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Selby</b>				14. MOTHER'S MAIDEN NAME <b>Tabby Purnell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Adam Adkins, Rt #1., Newark, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-vascular Disease</b> DUE TO (c) <b>Chronic Bronchial Asthma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>Several Years</b> <b>n</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/16/57</b> , 19__, to <b>4/18/60</b> , 19__, that I last saw the deceased alive on <b>4/18/60</b> , 19__, and that death occurred at <b>11:30 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ivory U. Sully, Jr.</b>		M.D.		ADDRESS (Street, city or town, state) <b>Flower St., Berlin, Md</b>		DATE SIGNED <b>4/29/60</b>	
PHYSICIAN'S NAME (Type) <b>Ivory U. Sully, Jr., M.D.</b>		Berlin, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Newark, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley, Salisbury, Md</b>				ADDRESS <b>DATE MAY 3 '60</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Received of Mr. J. M. Smith  
the sum of \$100.00  
for the purchase of  
the land on which  
the building is to be  
erected.

Witness my hand and seal  
this 1st day of January  
1880.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65175

5188

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Rayfield</u> Middle <u>Armstrong</u> Last <u>Armstrong</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10 - 1860</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State of foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lurnell Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Bishop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Madeline Armstrong</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular disease</u> 422.1 DUE TO <u>skilled</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>skilled</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>skilled</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1959</u> to <u>4/6</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>April 4</u> 19 <u>60</u> , and that death occurred on <u>April 11</u> 19 <u>60</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ivory U. Sully Jr. M.D.</u>		22b. DATE SIGNED <u>4-12-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully Jr. M.D.</u>		22d. ADDRESS <u>Berlin, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>April 13/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Ginn</u>		25a. REC'D BY REGISTRAR <u>Charles S. Kraus</u>	
ADDRESS <u>Snow Hill, md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	
DATE <u>APR 13 '60</u>			

1917

STATE OF ILLINOIS

1917

412

1

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

5183

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05176

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 GRAHAM AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLACE DASHA CROPPER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 24 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 16, 1890</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>SAMUEL CROPPER</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE GAULT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-324189</u>		17. INFORMANT Address <u>MRS. W. D CROPPER BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u>							
DUE TO (b) <u>Hypertension</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1-1-55</u> to <u>4-24-60</u> , that (I) (we) last saw the deceased alive on <u>4-5-60</u> and that death occurred <u>10:00 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Clifford E. Schott</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT M.D.</u>				22d. ADDRESS <u>BERLIN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/26/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burdge</u>				25a. REC'D BY REGISTRAR DATE <u>APR 28 60</u>			
25b. REGISTRAR'S SIGNATURE <u>Clifford E. Schott</u>							

1911

CERTIFICATE OF DEATH



Attest that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Registrar of the County of [illegible] State of [illegible]

Witness my hand and the seal of said County at [illegible] this [illegible] day of [illegible] 1911

[illegible Signature]

Attest that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Registrar of the County of [illegible] State of [illegible]

Witness my hand and the seal of said County at [illegible] this [illegible] day of [illegible] 1911

[illegible Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5189  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65177

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
3. NAME OF DECEASED (Type or print) First <u>Lorenia</u> Middle <u>Davies</u> Last <u>Davies</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1906</u> 54/3/8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-2553</u>	
17. INFORMANT <u>Mrs. Magnolia Mills</u> Address <u>35 West Ave. Hyattsville, Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia &amp; inanition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1957</u> to <u>April 18, 1960</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1960</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Lamar</u>		22b. DATE SIGNED <u>4-23-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. LAMAR</u>		22d. ADDRESS <u>104 Bay St. Snow Hill, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 20/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Dennis</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>APR 25 '60</u>	

State of

County of

City of

I, the undersigned, do hereby certify that

the within and foregoing is a true and correct copy of

the original as the same appears from the records of

the office of the Registrar of Deaths for the City and County of

the State of

in and to which said City and County of

the State of

the within and foregoing is a true and correct copy of

the original as the same appears from the records of

the office of the Registrar of Deaths for the City and County of

the State of

in and to which said City and County of

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the within and foregoing is a true and correct copy of

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the office of the Registrar of Deaths for the City and County of

the State of



TO DEPENDENT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65178

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY (RURAL)</u> c. LENGTH OF STAY IN lb <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01.4 d. STREET ADDRESS <u>5236 LINDEN HEIGHTS</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Isadore Conrad Franz</u> First Middle Last <b>4. DATE OF DEATH</b> <u>April 28 1960</u> Month Day Year				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>APRIL 3, 1884</u> <b>9. AGE</b> (In years last birthday) <u>76 yrs.</u> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED TREASURER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ELECTRICAL UNION</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>GERMANY</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>				<b>13. FATHER'S NAME</b> <u>unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Richard (discontinued)</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <b>17. INFORMANT</b> <u>MR. RICHARD H. FRANZ, 2628 MATTHEWS DR. BALTO 34 MD</u> Address				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure sec</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> DUE TO <u>Coronary Artery Disease c</u> <u>2 yrs</u> DUE TO <u>degenerative myocarditis</u> <u>2 yrs</u> (c) <u>cause lost.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> @ 11 P.M.							
<b>ACTUAL SIGNATURE</b> <u>Herman C. Rahlus</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>4/28/60</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>5/2/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>LORRAINE PARK</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anna A. Burboye Berlin Md.</u> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> <u>MAY 2 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Age: \_\_\_\_\_ Sex: \_\_\_\_\_

3. Date of Death: \_\_\_\_\_

4. Place of Death: \_\_\_\_\_

5. Cause of Death: \_\_\_\_\_

6. Manner of Death: \_\_\_\_\_

7. Signature of Medical Examiner: \_\_\_\_\_

8. Signature of Coroner: \_\_\_\_\_

9. Signature of Registrar: \_\_\_\_\_

10. Signature of Physician: \_\_\_\_\_

11. Signature of Nurse: \_\_\_\_\_

12. Signature of Undertaker: \_\_\_\_\_

13. Signature of Burial: \_\_\_\_\_

14. Signature of Interment: \_\_\_\_\_

15. Signature of Cremation: \_\_\_\_\_

16. Signature of Other: \_\_\_\_\_

17. Signature of Other: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Signature of Other: \_\_\_\_\_

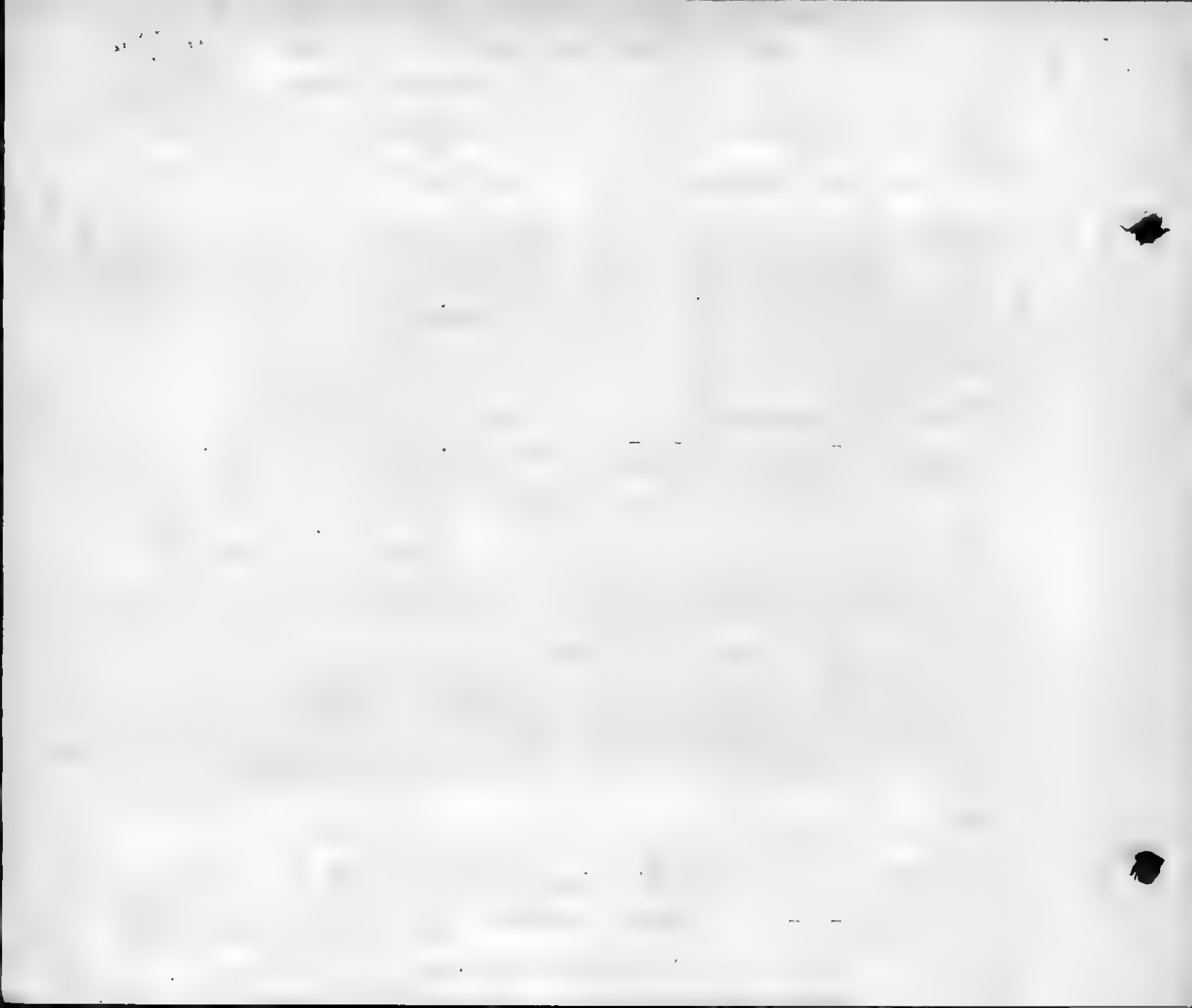
20. Signature of Other: \_\_\_\_\_

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please enclose a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65179  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Virginia b. COUNTY Accomack ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Snow Hill		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Hall			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last DARIUS THOMAS HALL				4. DATE OF DEATH Month Day Year April 24 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asa D. Hall				14. MOTHER'S MAIDEN NAME Mary Justice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 228-14-3303		17. INFORMANT Claude E. Hall, Snow Hill, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis (b) Semiology (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE N. E. Sartorius M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) N. E. SARTORIUS, SR. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/25/60 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-27-60 22c. NAME OF CEMETERY OR CREMATORY Martle Cemetery 22d. LOCATION (City, town, or county) (State) Sanford Virginia 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Henry H. Watson Pocomoke City, Md. 24a. REC'D BY REGISTRAR DATE MAY 2 '60 24b. REGISTRAR'S SIGNATURE Charles S. Krawitz							



5184

CERTIFICATE OF DEATH

65180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>X BERLIN</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>VERA</b> Last <b>HASTINGS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 2, 1889</b> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>PARSONSBURG MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEVIN DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>SARA GIVENS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>214-32-6978</b>	
17. INFORMANT <b>MR. LOG HASTINGS</b>		Address <b>BERLIN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, 331X</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Diabetes mellitus Myocarditis hyperten</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Diabetes mellitus Myocarditis hyperten</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> 19 <b>47</b> to <b>April 9, 1960</b> , that I last saw the deceased alive on <b>April 9, 1960</b> and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herman A. Robbins</b> M.D.		ADDRESS (Street, city, or town, state) <b>Berlin, Md</b> DATE SIGNED <b>4/14/60</b>	
PHYSICIAN'S NAME (Type) <b>Herman A. Robbins M. D.</b>		<b>Berlin, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/14/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS</b>	22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage</b> ADDRESS <b>Berlin Md</b>		24a. REC'D BY REGISTRAR DATE <b>APR 14 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

334x



may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5185

Item 1b, c, film G261

4/21/60 ink

65181

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Berlin Nursing Home</b>				d. STREET ADDRESS <b>13 MAIN ST</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>IRUNSHIRE</b> Last <b>HOLLOWAY</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 6, 1884</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b>0</b> Min.	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HORACE F. HARMUNSON</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA LINGO</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NO</b>		17. INFORMANT <b>MR. WILLIAM L. HOLLOWAY</b> Address <b>Ocean City Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>421.4 Acute Endocarditis</b> DUE TO (b) <b>Chr. Myocarditis</b> DUE TO (c) <b>Age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>0</b> m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1 - 1960</b> , to <b>April 19 - 1960</b> , that (I) (we) last saw the deceased alive on <b>4-18-1960</b> , and that death occurred at <b>5:00 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Chas. R. Law</b>				22b. DATE SIGNED <b>4-21-1960</b>		22c. PHYSICIAN'S NAME (Type) <b>Berlin Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/21/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		23d. LOCATION (City, town, or county) (State) <b>BERLIN Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Anna H. Burbage</b> Address <b>Berlin Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 185182  
5133  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHALEYVILLE</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X WHALEYVILLE</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH ELIZABETH HUDSON</b>		4. DATE OF DEATH Month Day Year <b>APRIL 10 1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 28, 1878</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico Co., MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSIAH CAREY</b>		14. MOTHER'S MAIDEN NAME <b>NANCY CAREY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>	
17. INFORMANT <b>Mr. URIAH HUDSON, WHALEYVILLE MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>44?X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>26 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-30-1960</b> to <b>4-10-1960</b> , that I last saw the deceased alive on <b>4-10-1960</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Chas. R. Law M.D. Berlin Md. 4-12-1960</b>			
ACTUAL SIGNATURE <b>Chas. R. Law</b>		PHYSICIAN'S NAME (Type) <b>Chas. R. Law</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/13/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>NEW HOPE</b>	22d. LOCATION (City, town, or county) (State) <b>WILLARDS (RED) MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur R. Burhage</b>		ADDRESS <b>Berlin Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

331X

5184

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 5183

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>	
f. STREET ADDRESS		g. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>--</b> Last <b>JESTER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1888</b>
9. AGE (in years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Gaddie Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs Lessie Lankford, Snow Hill, Md.</b>		Address <b>RFD 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (c) <b>stating the underlying cause last.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>N. E. Sartorius Sr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>N. E. SARTORIUS SR.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/24/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-27-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rural Pocomoke City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Watson</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 2 '60</b>	
ADDRESS <b>Pocomoke City, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5195

CERTIFICATE OF DEATH

65184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Bay Road</b>				d. STREET ADDRESS <b>Bay Road</b>			
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>BREM</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1893</b>	9. AGE (In years last birthday) <b>67</b> yrs	IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.	IF UNDER 24 HRS. Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George M. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Sarah A. Conner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 218-12-1320</b>		17. INFORMANT <b>Mrs Maude M. Jones, Stockton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Dec 1958</b> , to <b>April 20, 1960</b> , that I last saw the deceased alive on <b>Feb 1960</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>C. E. Critcher</b> M.D. <b>John C. Critcher</b> PHYSICIAN'S NAME (Type) <b>C. E. CRITCHER, M.D.</b> <b>New Church, Virginia</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-24-60</b>		22c. NAME OF CEMETERY <b>Wesley Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Stockton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 25 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>X BERLIN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDNA FRANCIS KELLY</b>		4. DATE OF DEATH Month Day Year <b>APRIL 4 1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 27, 1895</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW BEDFORD MASS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT M. GRAY</b>		14. MOTHER'S MAIDEN NAME <b>EMILY F. BARKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>	
17. INFORMANT <b>MRS ETHEL I. JOHNSON, MARIAN, MASS.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute myocarditis</b> <b>- 444 x</b> DUE TO <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>hypertension</b> DUE TO (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-4-60</b> to <b>4-4-60</b> that I last saw the deceased alive on <b>4-4-60</b> and that death occurred on <b>4-4-60</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Clifford E. Schott</b> M.D. <b>Berlin Md</b>			
PHYSICIAN'S NAME (Type) <b>CLIFFORD E. SCHOTT MD BERLIN MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OLD LANDING</b>	22d. LOCATION (City, town, or county) (State) <b>MARIAN MASS.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage</b> ADDRESS <b>Berlin Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 8 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Clifford E. Schott</b>

12 HOURS FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5196

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

65186

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. LENGTH OF STAY IN It <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willard Randolph Marshall</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1934</u>
9. AGE (In years last birthday) <u>25</u> yrs		10. IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Ranzell Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Sara Ginn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-20-3284</u>	
17. INFORMANT <u>Elizabeth Marshall</u>		Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage Lung</u> DUE TO <u>Fire arms - (Bullets &amp; Gun shot)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Gun shot</u> DUE TO (c) <u>Gun shot</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gun shot</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot twice through chest - Bullets around</u>	
20c. TIME OF INJURY Month, Day, Year <u>Apr. 23, 1960</u> Hour, a. m. <u>2</u> p. m. <u>30</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Sign Post Pocomoke Co., Va.</u> (County) <u>Stafford</u> (State) <u>Va.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Apr. 26, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>		22d. LOCATION (City, town, or county) <u>Stafford</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 2 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. L. Harris</u>	

TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for you. Yes.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





5197

CERTIFICATE OF DEATH

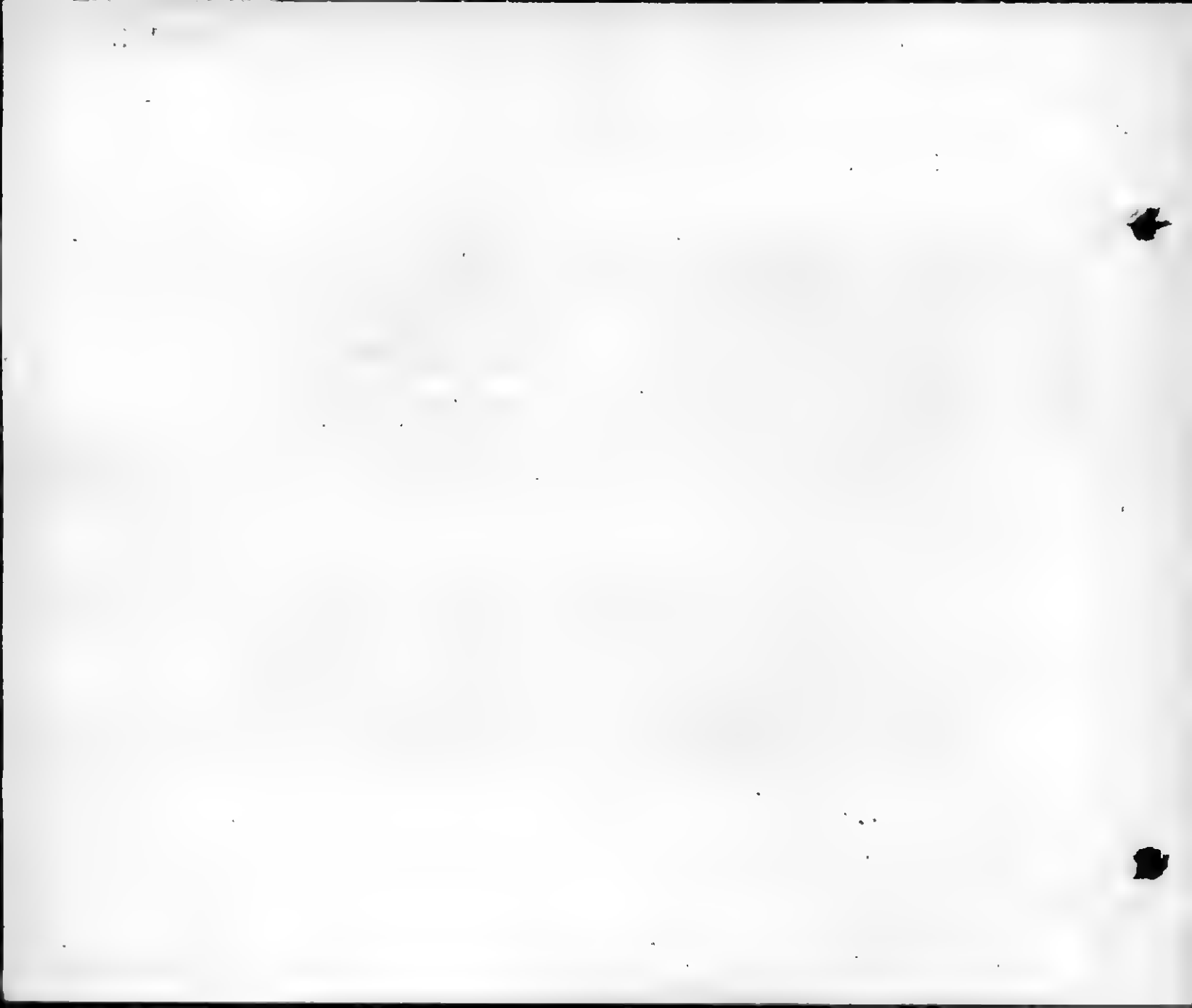
65187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>HE'S</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>PURNELL</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>22</u> - Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ind</u>
13. FATHER'S NAME <u>Milton Purnell - 29 YRS</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE PURNELL - 25 YRS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT Mother</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Prematurity</u> 5 <sup>th</sup> moa DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry U. Sully, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>Berlin, Md</u> DATE SIGNED <u>4/26/60</u>	
PHYSICIAN'S NAME (Type) <u>Henry U. Sully, Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Salley</u> ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR <u>MAY 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000254XV1



TO DE THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

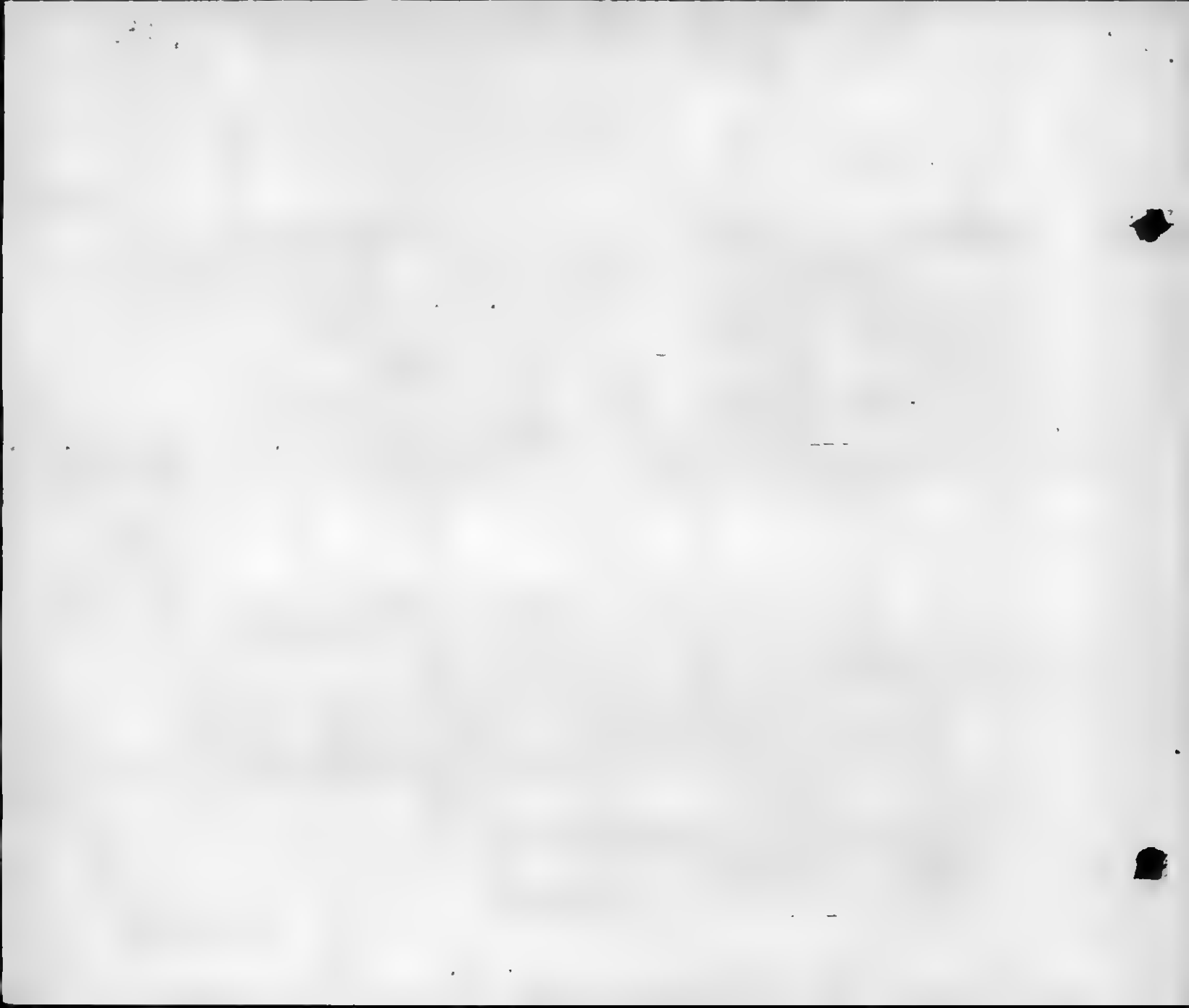
VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5188

5188  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Pocomoke City</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD 3</b>				d. STREET ADDRESS <b>RFD 3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>REDDEN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1937</b>	
9. AGE (In years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Mln. <b>22</b>		IF UNDER 24 HRS. Months <b>22</b> Days <b>22</b> Hours <b>22</b> Mln. <b>22</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Ray F. Redden</b>				14. MOTHER'S MAIDEN NAME <b>Doris May Truitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Ray F. Redden, RFD 3, Pocomoke City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epileptic Attack</b> DUE TO <b>Epilepsy (Right Motor Grand Mal)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death 5 minutes</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>---</b> p. m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>N. E. Sartorius, Sr.</b> EXAMINER'S NAME (Type) <b>N. E. SARTORIUS, SR.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>4/25/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-25-60</b>		22c. NAME OF CEMETERY <b>Bethany Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert N. Watson</b> ADDRESS <b>Pocomoke City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5199

## CERTIFICATE OF DEATH

05189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b>			
c. LENGTH OF STAY IN TB <b>30Yrs</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XX</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>XX</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>S.</b> Last <b>RINGLER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1883</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agent</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Seth Ringler</b>				14. MOTHER'S MAIDEN NAME <b>Lida Holton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>222-05-3914</b>		17. INFORMANT <b>Mrs. Amanda Ringler Bishopville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Arteriosclerotic heart disease</b> (b) <b>Arteriosclerotic heart disease</b> DUE TO <b>Arteriosclerotic heart disease</b> (c) <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>a few minutes</b> <b>several yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Jan</b> , 1960, to <b>Death</b> , that I last saw the deceased alive on <b>21 Apr</b> , 1960, and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Earl B. McFadden</b>		ADDRESS (Street, city or town, state) <b>Selbyville, Del.</b>		DATE SIGNED <b>23 Apr '60</b>			
PHYSICIAN'S NAME (Type) <b>Earl B. McFadden</b>							
22a. BURIAL CREMATION, (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/24/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>I. O. O. F.</b>		22d. LOCATION (City, town, or county) (State) <b>Bishopville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Selbyville, Del.</b>				24a. REC'D BY REGISTRAR <b>APR 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanes</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5190

Reg. Dist. No.

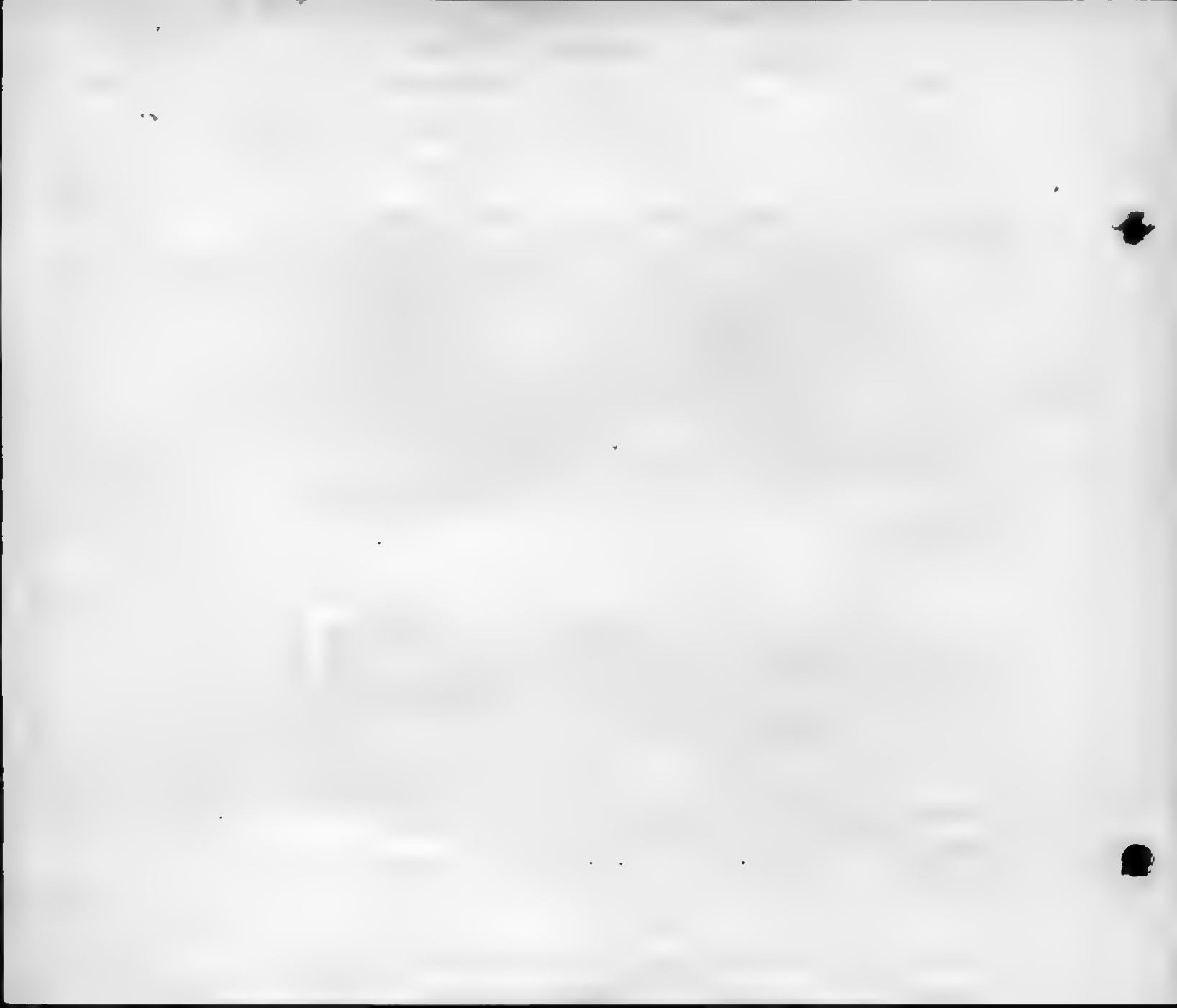
5200

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Worcester County, Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Md. Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Md. Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Hannah</u> Last <u>Thomas</u>				4. DATE DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Curtis Duke</u>				14. MOTHER'S MAIDEN NAME <u>Mora Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO <u></u>		17. INFORMANT <u>Wm. Thomas</u> Address <u>Berlin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Chronic</u> <u>443x</u> DUE TO						<u>2 yrs.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>Hypertension</u> DUE TO <u>5-10 yrs</u>	
(c) <u>Atherosclerosis</u> DUE TO <u>5-10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month. Day. Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>4-27</u> , 19 <u>60</u> that I lost saw the deceased alive on <u>4-27</u> , 19 <u>60</u> , and that death occurred at <u>1:31 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Worcester Maryland</u> DATE SIGNED <u>Frank R. Lewis</u>							
ACTUAL SIGNATURE <u>Frank R. Lewis</u> M.D. <u>Worcester Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Frank R. Lewis M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Buckingham</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Burbo</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Kneal</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please enclose it with this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
5187 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 05191										
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Worcester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1					d. STREET ADDRESS 627 Bank St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Wm</i> First Middle Last <i>Alexander Tucker</i>					4. DATE OF DEATH Month Day Year <i>April 7 19 60</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 15 - 1912</i>		9. AGE (in years last birthday) <i>47 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Appliance</i>		11. BIRTHPLACE (State or foreign country) <i>Atlanta Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Tucker</i>					14. MOTHER'S MAIDEN NAME <i>Martha Flowers</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>252-09-223</i>		17. INFORMANT <i>Edna H Tucker</i> Address <i>Pocomoke City, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.3</i> DUE TO <i>Pulmonary Edema (Severe)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>b) Drowning in brine</i> DUE TO <i>Arteriosclerotic Heart Disease</i> (c) <i>(?)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Brief</i>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell flat on abdomen with head bent over and immersed in a tank of freezing brine</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>- 19 60</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Pocomoke City, Worc. Md.</i>		20f. (City or town) (County) (State) <i>Pocomoke City, Worc. Md.</i>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>M. E. Sartorius Sr.</i> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>N. E. Sartorius, Sr.</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-16-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Atlanta</i>			22d. LOCATION (City, town, or county) (State) <i>Atlanta, Georgia</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - Newchurch, Va.</i>					ADDRESS		24a. REC'D BY REGISTRAR DATE <i>APR 21 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Jones</i>	

Chas. med. Ex. here -  
reported "Drowning"

5201

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BISHOP R.F.D.</b>		c. LENGTH OF STAY IN lb <b>45YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D.2</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BISHOP R.F.D.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>M. EDGAR WATERS</b>		4. DATE OF DEATH Month Day Year <b>4 3 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/1883</b>
9. AGE (In years, months, and days) <b>76</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during usual working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MORRIS WATERS</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HUDSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JOSEPHINE WATERS BISHOP, MD. R.F.D.2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-vascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Diabetes mellitus</b> (b) <b>Sensility</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-23</b> , 19 <b>56</b> , to <b>4-2</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4-2</b> , 19 <b>60</b> , and that death occurred at <b>4:35p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ivory U. Sully Jr. M.D.</b>		ADDRESS (Street, city or town, state) <b>Berlin, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Ivory U. Sully Jr. M.D.</b>		DATE SIGNED <b>4/4/60</b>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/6/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SARAH DUKES CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BISHOP, MD. R.F.D.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ronald James</b>		ADDRESS <b>MILLSBORO, DEL.</b>	
24a. REC'D BY REGISTRAR <b>APR 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knecht</b>	

MEDICAL CERTIFICATION

TO HO: AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

